

**Office of Infectious Disease Epidemiology and Outbreak Response**

**Division of Outbreak Investigation**

**Outbreak Summary Report: RESPIRATORY ILLNESSES (NON-COVID-19) at a HEALTHCARE FACILITY**

**MDH Outbreak #**

**Facility Name:** \_\_\_\_\_ **County:** \_\_\_\_\_  
**Circle facility type:**  Nursing home  Assisted Living  Other:

**Illness:** \_\_\_\_\_ **Date of Final Report:** \_\_\_\_\_  
(NOTE: If there are several types of illnesses (e.g. pneumonia, ILI, etc.), please indicate the most prevalent illness in this outbreak—see MDH Guidelines for definitions.)

**I. INTRODUCTION:**

Date outbreak reported to LHD: \_\_\_\_\_  
Who reported outbreak to LHD: \_\_\_\_\_  
Name of facility's IP: \_\_\_\_\_ Has the IP taken a training course?  Y  N  
Who at LHD conducted the investigation: \_\_\_\_\_  
Date infection control recommendations were given to facility by LHD: \_\_\_\_\_  
Date LHD reported outbreak to DHMH: \_\_\_\_\_  
Primary contact for outbreak at DHMH: \_\_\_\_\_

**II. BACKGROUND:**

Total number of residents at facility: \_\_\_\_\_  
If outbreak was in one unit, number of residents in that unit: \_\_\_\_\_  
Total number of staff at facility: \_\_\_\_\_  
If outbreak was in one unit, number of staff in that unit: \_\_\_\_\_

Influenza vaccination coverage rate among residents: \_\_\_\_\_ (express as a fraction or %)  
Pneumococcal vaccination coverage rate among residents: \_\_\_\_\_ (express as a fraction or %)  
Influenza vaccination rate among staff: \_\_\_\_\_ (express as a fraction or %)

**III. CLINICAL RESULTS:**

**RESIDENTS:**

# of cases (TOTAL\*) \_\_\_\_\_  
# with lab-confirmed influenza \_\_\_\_\_  
# with ILI \_\_\_\_\_  
# co-infected with COVID \_\_\_\_\_  
# with pneumonia \_\_\_\_\_  
# of hospital admissions \_\_\_\_\_  
# of ER visits \_\_\_\_\_  
# of deaths related to outbreak \_\_\_\_\_

**STAFF:**

# of cases (TOTAL\*) \_\_\_\_\_  
# with lab-confirmed influenza \_\_\_\_\_  
# with ILI \_\_\_\_\_  
# co-infected with COVID \_\_\_\_\_  
# with pneumonia \_\_\_\_\_  
# of hospital admissions \_\_\_\_\_  
# of ER visits \_\_\_\_\_  
# of deaths related to outbreak \_\_\_\_\_

\*Total = number with ILI, influenza, or pneumonia.

Onset date range for entire facility, i.e. residents and staff (first to last): \_\_\_\_\_  
Onset date range for residents only (first to last): \_\_\_\_\_  
Onset date range for staff only (first to last): \_\_\_\_\_

*-Please attach an epi curve*

Duration of symptoms for cases:    shortest:                    longest:                    median:

Was the outbreak limited to one floor or wing?                     YES                     NO  
 If YES, please list floor/wing # and/or name:

Were antivirals (e.g. oseltamivir) given as part of this outbreak?                     YES                     NO  
 If YES, please list which antiviral(s):

Which categories of individuals received antivirals?

- Residents with lab confirmed influenza
- All well residents
- Ill staff
- Residents with ILI or other respiratory illness
- Some well residents
- Well staff

Other:

Duration of antiviral prophylaxis:

**Symptom frequency for cases:**

***Residents:***

Symptom	Number with Symptom
Fever	
Cough	
Sore Throat	
Runny Nose	
Congestion – Nasal	
Congestion - Chest	
Shortness of breath	
Muscle Aches	
Chills	
Loss of taste/smell	
Vomiting	
Diarrhea	

***Staff:***

Symptom	Number with Symptom
Fever	
Cough	
Sore Throat	
Runny Nose	
Congestion – Nasal	
Congestion - Chest	
Shortness of breath	
Muscle Aches	
Chills	
Loss of taste/smell	
Vomiting	
Diarrhea	

If symptom frequency is unavailable, please list predominant symptoms of this outbreak.

**IV. RADIOLOGY AND LABORATORY RESULTS:**

	Number performed	Number positive
Chest X-ray (CXR)		

Please provide any notes relating to findings of any positive CXRs

Test	Number Collected	Number Positive	Agent identified
PCR for influenza			
Rapid influenza test			
Bacterial sputum culture			
COVID antigen test			
COVID PCR test			
<i>Legionella</i> urine antigen			
<i>Legionella</i> culture			
Blood culture			
Other:			

**V. CONCLUSION(S):** (Please complete *either* #1a or #1b, *and* #2-6)

1a. Please list the lab-confirmed etiology of the outbreak:

Is the above etiologic agent consistent with the observed course of this outbreak?

YES                       NO                       UNKNOWN

1b. If an etiology was not lab-confirmed, the etiology of the outbreak is believed to be:

Briefly, the evidence for this conclusion includes:

2. How do you think the outbreak was initiated?

3. Please describe changes (if any) in infection control practices at the conclusion of the outbreak.

4. Was a site visit done?     YES                       NO                      Date:

Observations made during the visit:

5. What recommendations were issued at the beginning and conclusion of the outbreak investigation?

Were admissions to the facility restricted?     YES                       NO

Entire facility                      Dates restricted:                      to                      Unit:                      Dates restricted:                      to  
Unit:                      Dates restricted:                      to                      Unit:                      Dates restricted:                      to  
Unit:                      Dates restricted:                      to                      Unit:                      Dates restricted:                      to

6. Please note any other pertinent information.

CC LIST

LTCF Official:                      Date Sent: